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Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania

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ABSTRACT

Young people – particularly girls and young women in sub-Saharan Africa – face significant challenges accessing sexual and reproductive health information and services. These challenges are shaped in part by sociocultural factors, including stigma. This paper presents findings from a qualitative study that explored the micro-level social process of stigma surrounding young people's sexual and reproductive health in two communities in Tanzania. Respondents described an environment of pervasive stigma surrounding the sexual and reproductive health of unmarried young people. Stigma manifested itself in multiple forms, ranging from verbal harassment and social isolation to physical punishment by families, community members, peers and healthcare providers. Respondents perceived that stigma was a barrier to young people accessing sexual and reproductive health services and identified excessive questioning, scolding and requirements to bring sexual partners or parents to receive services at health facilities as obstacles to accessing care. The pervasiveness and complexities of stigma surrounding young people's sexual and reproductive health in the two study communities and its potential consequences for health suggest both a need for care in using the term stigma as well as further studies on the feasibility of incorporating stigma-reduction strategies into young people's sexual and reproductive health programmes.

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Introduction

Young people – particularly unmarried young sub-Saharan African women Africa – face numerous sexual and reproductive health challenges (Bearinger et al. 2007; UNAIDS 2014). Constrained access to sexual and reproductive health services and information contributes to increasing the risk of unplanned pregnancy, unsafe abortion and sexually transmitted infections (STIs) (Speizer et al. 2000; Sidze et al. 2014). Sexual activity begins early in Tanzania: approximately 10% of young people begin having sex by age 15 (Tanzania Commission for AIDS, Zanzibar AIDS Commission, NBS, Office of the Chief Government Statistician, and ICF International 2013) and 45.5% of girls and 37.5% of boys ages 15–19 are sexually active (NBS

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and ICF Macro 2011). Despite high contraceptive knowledge, young people's contraceptive use remains low (Tanzania Commission for AIDS, Zanzibar AIDS Commission, NBS, Office of the Chief Government Statistician, and ICF International 2013). Indeed, only 16% of married and unmarried women aged between 15–24 years reported ever having used a contraceptive method (NBS and ICF Macro 2011) and more than one in four young women (27%) aged between 15 and 19 years are pregnant or already mothers (Ministry of Health, Community Development, Gender, Elderly and Children [Tanzania Mainland], Ministry of Health [Zanzibar], NBS, Office of the Chief Government Statistician, and ICF International 2016). Due to early sexual debut and limited use of contraception, young people in Tanzania face unplanned pregnancies, unsafe abortions and STIs (UNFPA 2007; Plummer et al. 2008; Doyle et al. 2010; Ross 2010).

Despite decades of effort to improve adolescent-friendly services, access remains challenging (Glinski, Sexton, and Petroni 2014). This challenge is shaped in part by sociocultural factors, including stigma (Bearinger et al. 2007; Mbeba et al. 2012; Woog et al. 2015; Newton-Levinson, Leichliter, and Chandra-Mouli 2016). For example, cultural and political taboos, traditional values and attitudes surrounding adolescent sexuality may affect legislation on confidentiality, the promotion of sexual and reproductive health services and the prevention of early marriages and early or unintended pregnancy (Utomo and McDonald 2009; Jaruseviciene, Lazarus, and Zaborskis 2011; Obare, Birungi, and Kavuma 2011). Within healthcare facilities, providers' preconceived notions of appropriate sexual behaviour based on age, gender or marital status may influence the quality of the information and services provided (Wood and Jewkes 2006; Nalwadda et al. 2011).

Stigma, a complex social process with power 'playing a key role in producing and reproducing relations' of social control (Parker and Aggleton 2003, 16), is receiving increasing attention with respect to its ability to shape health and life opportunities (Angermeyer et al. 2014; Phelan et al. 2014). Some argue that stigma, in addition to factors such as socioeconomic status, is a fundamental determinant of health and health inequity (Hatzenbuehler, Phelan, and Link 2013). This perspective illustrates how stigma undermines three key determinants of health – access to resources, social support and psychological and behavioural responses – through exclusion, segregation, discrimination, stress and downward socioeconomic placement. Additional work has reinforced this conceptualisation of power as central to the process of stigma, focusing on how structural stigma creates social structures that keep 'others' down (Link and Phelan 2014). The importance of power is also emphasised in Link and Phelan's (2001) conceptualisation of stigma, which describes stigma as occurring when labelling, stereotyping, separation, status loss and discrimination come together within the context of power imbalance. Without exerting power, one can label, stereotype and work towards separation but will not inflict status loss and discrimination (Link and Phelan 2001). Ultimately, stigma fully exercised leads to the social, economic and political exclusion of individuals or groups; reduces their life chances; and often increases their vulnerability to negative health outcomes (Hatzenbuehler and Link 2014; Link and Phelan 2014).

Although stigma has been measured and documented as a barrier to the prevention, diagnosis and treatment of several health conditions (Corrigan 2004; Mahajan et al. 2008; Chambers et al. 2012; Chang and Cataldo 2014), it has been less thoroughly investigated with respect to adolescent sexual and reproductive health. Stigma is regularly listed as one barrier among others in studies of young people's sexual and reproductive health, as documented in a review of barriers to STI care for adolescents (Newton-Levinson, Leichliter, and

Chandra-Mouli 2016). However, more in-depth explorations of this type of stigma remain lacking. Indeed, whereas all of the studies included in that review list stigma as a barrier to care, none focused specifically on stigma and few explored it in depth (Newton-Levinson, Leichliter, and Chandra-Mouli 2016). Recognising that the lives of young people are complex and shaped by many factors and processes that create and reinforce vulnerability and risk, this paper examines one of these processes: the social process of stigma surrounding young people's sexual and reproductive health at the community level. We explore the micro-level stigmatisation process by analysing its presence, forms and potential implications for young peoples' access to sexual and reproductive health information and services in two communities in Mwanza Region, Tanzania.

Policy context

Young people in Tanzania were only recognised as a population in need of contraceptive services and information in 1994. The revised national policy guidelines from that year stated that adolescents, irrespective of their parity and marital status, have a right to access family planning and emphasised the provision of adolescent-appropriate information, education and counselling without including specific guidance on what constitutes such services (Ministry of Health 1994). More recent family planning policies provide additional guidance, stating that relevant information and education materials should be displayed or distributed to young people and that young people should be able to obtain preventive, rehabilitative and curative services that are appropriate to their needs (Ministry of Health and Social Welfare 2013). However, neither standard specifically defines the terms 'relevant' or 'appropriate'.

In addition to national policies, the Tanzanian government has released several manuals detailing standard practices for STI care. These practical guidelines encourage contact referral (tracing) or partner notification as an effective means of breaking the transmission chain. They also highlight the provider's responsibility to assist with partner notification and to encourage patients to test for HIV (Ministry of Health and Social Welfare 2007, 2008). These manuals do not include guidance or flexibility with respect to the context of an individual client, such as an unmarried young person, and lack clarity around parental involvement with respect to youth under the age of 18 years.

Methods

Conceptual frameworks relating to HIV and stigma (Link and Phelan 2001; Parker and Aggleton 2003; Mahajan et al. 2008; International Center for Research on Women and United Nations Development Program 2013) and the socioecological framework (Bronfenbrenner 1979; DiClemente et al. 2005) guided this exploratory qualitative study. Focus-group discussions and semi-structured, in-depth interviews were conducted to explore the process of stigma surrounding young people's sexual and reproductive health, focusing on the individual, intrapersonal and community levels, within two key community institutions – health facilities and schools – and its potential implications for health. Additionally, a literature review and policy scan were conducted to support the development of the data collection instruments and help contextualise the policies that guide the provision of sexual and reproductive health information and services.

Stigma may manifest itself in enacted, perceived, anticipated, internalised and secondary forms, as shown in Table 1.

Study population and sampling

Data were collected from two wards (one rural and one urban) in Mwanza Region, North-Western Tanzania. A total of 22 focus-group discussions (of six to eight respondents each) and 56 in-depth interviews were conducted (Table 2). Group discussions were structured around four hypothetical scenarios of young people facing unplanned pregnancy, contraceptive need, STIs and seeking sexual and reproductive health information. The in-depth interviews sought to elicit individual experiences from a range of groups (Table 3). Respondents were recruited through a mix of purposive and snowball sampling. Researchers worked with village authorities to identify adults (two women and two men) at each site, who in turn identified four young people to help recruit respondents. These eight individuals then recruited peers who met the inclusion criteria. Science teachers were recruited from all public schools in the two wards (two rural – one primary and one secondary school – and one urban – a secondary school). Healthcare providers in reproductive and child health departments were recruited from all three public health facilities (one rural and two urban). Three non-governmental organisations working with young people in the study communities were approached; however, only one interview was completed with a programme officer. The study was unable to conduct primary data collection at the policy level.

Table 1. Types of stigma.

Enacted	Stigma that is experienced through interpersonal acts of discrimination
Secondary	Stigma extended to family or other caregivers of stigmatised individual
Perceived	Perception of the prevalence of stigmatising attitudes in the community or among healthcare providers
Anticipated	Fear of stigma, whether experienced or not
Internalised	Act of accepting stigma as true and just

Table 2. Overview of focus-group discussions and in-depth interviews.

	Focus-group discussions ($n = 22$)		In-depth interviews* ($n = 56$)	
Participant category	Rural	Urban	Rural	Urban
Young women aged 14–24*				
In-school	2	1	4	2
Out-of-school, never pregnant	1	2	2	2
Out-of-school, experienced pregnancy	1	1	4	4
Young men aged 14–24*				
In-school	2	1	4	2
Out-of-school	2	1	4	2
Parents*				
Mothers	3	1	4	3
Fathers	3	1	5	1
Professionals				
Teachers	–	–	4	2
Healthcare providers	–	–	2	4
Non-governmental organisation worker	–	–	1	0
Total	14	8	34	22

*All parents and young people who participated in an in-depth interview had previously participated in a focus-group discussion.

Table 3. Adolescent and parent respondent characteristics.

Category	Average age	Average years of schooling	Total (n = 178)
Young women aged 14–24			
In-school	16.1	8.7	24
Out-of-school, never pregnant	17.8	–	24
Out-of-school, experienced pregnancy	20.0	7.5	17
Young men aged 14–24			
In-school	16.1	8.8	26
Out-of-school	19.0	7.2	21
Total young people	17.6	7.8	112
Parents			
Mothers	42.3	5.7	37
Fathers	47.5	6.2	29
Total parents	44.6	5.9	66

Ethical clearance

Ethical clearance was granted by the Medical Research Coordination Committee of the National Institutes of Medical Research, Mwanza and Health Media Labs, Washington, DC. The study acquired approval from village officers and school headmasters, and voluntary consent was obtained from all respondents and the parents of respondents under 18 years old. Given the sensitivity of the issues, efforts to preserve confidentiality and anonymity included collecting no identifying information and maintaining unlinked consent forms and transcripts. Respondents were informed about the study's purpose and the topics it would cover, that participation was voluntary and could be stopped at any point and that declining to participate would have no repercussions. Names were omitted during discussions (focus-group discussion respondents were assigned numbers) and moderators discouraged discussions about individual experiences.

Data analysis

Interviews were audio-recorded, transcribed verbatim, checked for accuracy and translated from Swahili to English. NVivo (version 10) was used to manage and explore the data. Coding started with open coding using respondents' language and combining emerging concepts with preconceived theoretical constructs. In all, 15% of the transcripts were double-coded to further refine the codes and ensure consistency between coders. After completing half of the coding, axial coding was applied to group open codes into abstract conceptual categories. Constant comparative techniques were used to analyse the data (Strauss and Corbin 1990). During analysis, the research team met to discuss predominant emerging themes. Queries were executed in NVivo to analyse themes across study populations.

Findings

Respondents across all categories described a pervasive process of stigma surrounding unmarried young people's sexual and reproductive health in their communities that could be roughly mapped to the four steps in Link and Phelan's (2001) conceptualisation of stigma (Figure 1). Respondents described manifestations of enacted, anticipated, perceived and secondary stigma, which grouped into negative name calling, shame, social and physical isolation, physical punishment, verbal harassment (scolding and excessive questioning) and

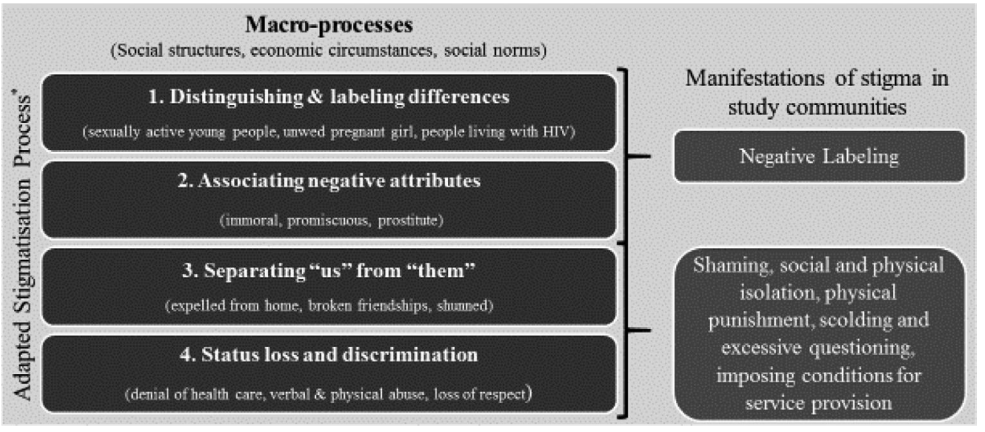

Figure 1. Analysis framework.

the imposition of conditionality for sexual and reproductive health services. As depicted in Figure 1, this community-level process of stigma is embedded within and influenced by larger social forces, including social norms, social contexts and economic circumstances; however, a detailed analysis of these forces is beyond the scope of this paper.

Negative name calling

All respondents described the commonplace derogatory labelling of adolescents who were known or assumed to be sexually active. Name calling also manifests itself as secondary stigma and extends to family members, peers and schools. It was generally described as worse for girls than boys and particularly harsh for girls who experienced unplanned pregnancy. For boys, names denounced promiscuity but almost praised sexual prowess, such as 'sex maniac' or 'sex expert':

> The boy can even have sex with them [women] and won't be referred to as a *mhuni* [hooligan, idler]. But once a girl, even if she has not had sex with 10 men, they will say she is a *malaya* [prostitute] … but the boy is never considered a *malaya*. (Out-of-school, girls, urban)

For girls, name calling focused more on sexual deviance. 'Prostitute' was the most common taunt, though other names included 'spoiled', 'cheap', 'easy' and 'ruined' and were experienced by girls who experienced unplanned pregnancy:

> Respondent 3: You prostitute [*malaya*], come here.
>
> Respondent 4: You for all [*cha wote*], you easy ride/cheap [*mteremko*].
>
> Respondent 5: Vegetables [cheap stuff], if you feel thirsty [feel a desire for sex] you go to so and so, she is our vegetable. (Out-of-school, experienced unplanned pregnancy, girl, urban)
>
> But you are not actually a prostitute, but they are just seeing you that way because you got pregnant, that you are a prostitute. But you are not, and you never expected to become pregnant. (Out-of-school, experienced unplanned pregnancy, girl, rural)

Shaming

The shaming of sexually active unmarried young people was an overriding theme that was so embedded in the discourse that it was difficult to disentangle from other forms of stigma.

It was also often used to explain the isolation, withdrawal of support for schooling or physical punishment that occurred:

> Some of the parents would say, 'No, you have given birth, none would take you to school, stay home, you just stay home.' … They would tell her that, 'You have shamed your family.' (Out-of-school, experienced unplanned pregnancy, girl, rural)

Bringing shame to oneself and one's family through sexual activity led to loss of social standing. The shaming of young people, particularly girls, was universally described and feared by the respondents, who were particularly conscious of the shame a daughter experiencing unplanned pregnancy brought to her parents, an example of secondary stigma:

> Once those neighbours see that child [pregnant], the respect for the family will go way down because she has brought shame to them as she is still very young. (Men, rural)

Social and physical isolation

Respondents detailed the process of separation and shunning used by the community to impose social isolation on sexually active young people. They also described a belief that if one young person were to engage in premarital sexual activity, it would increase the likelihood that their siblings or peers would follow suit. Therefore, parents forbade their children from befriending or being seen with other young people assumed to be sexually active; in some cases, young people made this choice on their own. This was particularly the case for young women who experienced unplanned pregnancy:

> If the community discovers [a girl is pregnant], some parents will forbid their children to befriend that [girl] …. If the parents see another girl walking with [her], they will say she too has started involving herself in issues of sex. (In-school girls, urban)

Physical isolation was described by respondents in terms of being expelled from home (or sent to live with a distant relative) or school in response to unplanned pregnancy either as punishment or as a means to hide the shame of pregnancy:

> Another parent might understand that his daughter is pregnant and may tell her to go and live with her aunt, so that she may not be seen, since it is very shameful for her to give birth while at home. (Healthcare provider, urban)

However, although expulsion from the home was feared, as explained here, it was not inevitable:

> I mean, I was afraid maybe they would chase me away from home … I thought I would be chased away because while I had seen some other girls who were kept at home, some others were chased away. So my heart was paining, as I didn't know whether mom would expel me. (Out-of-school, experienced unplanned pregnancy, girl, urban)

Physical punishment

Young people described fearing physical punishment (anticipated stigma) if it became known that they were sexually active or simply seeking sexual and reproductive health information. Adults confirmed that physical punishment occurred and was deserved:

> I saw them [daughter and friends], and when she found that I have seen her, she followed me saying 'Mum, you know my friends are fools …. They want to go and have injections so as not to become pregnant.' … To be honest, what I did was to pick up a stick, and I started beating her. (Mothers, rural)

Scolding and excessive questioning

Respondents reported that young people, especially those in school, risked being scolded or verbally harassed if it became known that they were sexually active or seeking sexual and reproductive health information or services. This occurred within healthcare facilities, families and the broader community. One young woman described how her peers and community members harrassed her during pregnancy:

> The other people laughed at me when I was pregnant. I had become pregnant while still at home …. They were just talking about me, 'The daughter of so and so is pregnant, let her give birth and become old, she will lose her market.' (Out-of-school, experienced unplanned pregnancy, girl, rural)

Adult men described the verbal harassment a young girl would face if she accessed treatment for an STI:

> To be honest, Jane will be received [get services] … but at the health centre or hospital, she will have a difficult time. First, she will be received with harrassments. She will be shouted at and bad mouthed that her age is young, yet she is suffering from this disease. Surely, she must be harrassed. (Fathers, rural)

Scolding and excessive questioning were also repeatedly described as forms of stigma that restricted access to services. Within health facilities, respondents reported that young people asking for contraception or other sexual and reproductive health services would be met with rude treatment and a barrage of what was described as disproportionate, unnecessary questioning. Questioning probed young people's schooling and relationship status, prior childbearing, the whereabouts of their partner or parent, their motivation for seeking contraception or the source of their STI:

> They [healthcare provider] will look at her age, which is small; then they will ask her, 'How come your age doesn't allow you and why should you do that? You are a child of fifteen years old; you have come for birth control? What has made you to indulge in sexual relationship, and yet, you are a young girl?' They will ask her many questions, because her age doesn't allow her [to have sex]. (Fathers, rural)

> I explained my complaint [symptoms of an STI]; there were some questions … I was asked my age … 'What is your occupation? Are you in school or out of school? How many partners do you have? Why have you decided to do this?' … The doctor …. He told me that, 'young man, study, life is school'. (Out-of-school boys, rural)

Young people believed that they would be subject to such questioning and scolding because of healthcare providers' reluctance to offer services related to 'promiscuous' behaviour. Adults' descriptions were consistent with the younger respondents' anticipated treatment at the health facility, and the term *kunyanyapaa* (to stigmatise) was specifically used:

> The nurse will not admit Sara [hypothetical character] in good manner/way, just by looking at her age [15 years]. Even if she will give her the service, it will not be the same service given to an adult woman … in fact, she can stigmatise her in giving the service. (Fathers, urban)

Imposing conditions for service provision

Both young and adult respondents anticipated that healthcare providers might impose certain conditions – that is, the accompaniment of the spouse/sexual partner or parent or that the individual have a certain number of children – before providing sexual and

reproductive health services to young people. Accessing contraception, antenatal care and treatment for STIs were all discussed as coming with conditions:

> She would be asked some questions … because she would be asked as she is too young to have those contraceptive pills …. If she says that she doesn't have any child, she wouldn't be given. (In-school girls, rural)

> It is not easy because going there at the health centre [to seek treatment for STIs]. You must be with your parent. That is when you will be received and given treatment. (In-school boys, rural)

> They were so surprised; they said 'your parents!' I just lied to them that I don't have parents, because if I had told them I had parents, they would have asked me to call my mother. Because they asked me to call my husband and I said he is not around … because if I had told him [the father of the child], he wouldn't go, he would be afraid … I told them I live alone, so they told me 'you are lucky, we have sympathised with you'. That's when they tested me. (Out-of-school, experienced unplanned pregnancy, girl, urban)

Potential consequences

Although the study size and design limited the number of young respondents with personal experiences around contraceptive use, pregnancy or STIs, respondents did describe perceived and anticipated stigma from family, community and healthcare providers as a barrier to accessing sexual and reproductive health services.

A general theme across groups was that young people avoid accessing contraceptives at health facilities due to fear of lack of confidentiality, denial of service, excessive questioning, negative labelling or being required to bring a parent:

> There are questions at the hospital. They will ask you, 'How many children do you have?' When you say one, they will tell you, 'You only have one child and you want to control birth?' I just decided to go to the pharmacy. (Out-of-school, experienced unplanned pregnancy, girl, rural)

> The girls don't come [for contraception], they fear …. They believe that when the girl takes pills or gets the injection, she is perceived to be a prostitute. (Healthcare provider, urban)

> So it feels that, the shame that makes me not to be able to get involved in asking for those things [contraception]. It is because I feel that how am I going to portray myself in front of that woman or in front of that man [healthcare providers]? (Out-of-school boys, urban)

Respondents also described how young people delayed, avoided, self-treated or used ineffective treatment for STIs for similar reasons, including fear of the need to bring a parent or sexual partner to receive services:

> These sexually transmitted infections, one needs quick advice with them, but in fact, many do not even go to hospital. They just take just medicines commonly found in the streets, traditional medicine, or someone could get them through the person who sells at the pharmacy. (Out-of-school girls, urban)

> They will discover that she is infected with sexually transmitted disease, she will be asked, 'Are you married? Who do you stay with? … You should come with your father or your mother.' (Mothers, rural)

Respondents described similar anticipated barriers to antenatal care, such as embarrassment, shame and fear of disclosure. Girls who experienced unplanned pregnancy described how fearing discriminatory treatment in the health facility and harassment within their communities hindered timely access:

> I waited to get antenatal care because I was afraid … I didn't want them to know I was pregnant. They only noticed when I was five months pregnant. (Out-of-school, experienced unplanned pregnancy, girl, rural)

> … at the street they saw me … they said a lot of words, until I was scared even to walk … they were saying things like, 'you are pregnant and left school so your mother is also stupid. If it was me, I mean, I would have kicked you out to go to that man who has given you pregnancy. Your mother still takes care of you, so maybe she is the one who was taking you [for sex].' (Out-of-school, experienced unplanned pregnancy, girl, urban)

Resilience

In addition to how stigma might impede young people from accessing sexual and reproductive health services, respondents also described how young people navigate anticipated stigma, including strategies to avoid disclosing sexual activity to their family or community. They reported that to maintain anonymity, young people seek services from pharmacies, shops, private clinics and distant healthcare facilities or by enlisting older siblings or friends to purchase contraception:

> They [girls], if it is pills, they can ask an adult woman, a friend, to get them. They can ask for a thousand shillings to go buy something [from parents]. Then, they give that to someone to go buy the pills for them. A girl cannot go where she is known – for example, if she is from here and she … [goes to the clinic], the women there will know her, so she would go instead to another place farther away. Girls are clever. She avoids hospitals, because she knows that someone there might know her. Instead, she goes to a certain pharmacy where she knows she can get Depo; she just pays two thousand shillings and gets Depo. I hear them [girls] discussing this. (Mothers, urban)

> It is easy to go if [the facility] is far away, somewhere where they do not know me at all. (Out-of-school boy, urban)

Discussion

Respondents across all study communities and respondent groups described an environment of perceived and anticipated stigma surrounding sexually active unmarried young people, particularly young women with unplanned pregnancies. At the family and community levels, respondents described a process of stigma playing out through pejorative name calling and labelling, social and physical isolation, physical punishment and shaming. Other studies have also documented one or more of these forms of stigma (Tangmunkongvorakul, Kane, and Wellings 2006; Tavrow, Withers, and McMullen 2012; Kennedy et al. 2013; McCleary-Sills et al. 2013; Newton-Levinson, Leichliter, and Chandra-Mouli 2016). For example, a qualitative study in southern Tanzania found that adolescent girls who experience unplanned pregnancy fear social stigma, name calling and rejection from their parents (McCleary-Sills et al. 2013).

Perceived and anticipated stigma in schools and health facilities was an extension of what respondents described at the familial and community levels: teachers shaming sexually active students, schools expelling pregnant girls and healthcare providers harassing, scolding and excessively questioning young people seeking sexual and reproductive health services. Respondents noted that healthcare providers may even deny young people care because of failing to bring a partner or parent. A 'mystery client' evaluation of healthcare providers'

reception of adolescents requesting condoms and sexual and reproductive health information revealed that providers often responded inadequately and with hostility in Tanzania (Mchome et al. 2015). Similarly, a qualitative study conducted in South Africa found that nurses scolded adolescent female clients and treated them harshly (Wood and Jewkes 2006).

Respondents described how the fears of being shamed, scolded, physically punished or isolated for sexual behaviour by family, peers and the community could act as barriers to young people seeking sexual and reproductive health services, lead to delays in care seeking or steer them to potentially less-qualified providers. Similarly, a multi-country study conducted in Africa determined that embarrassment, fear and other psycho-social factors hindered access to care (Biddlecom, Awusabo-Asare, and Bankole 2009). Respondents described an environment where a combination of anticipated questioning and scolding by healthcare providers, coupled with the expected imposition of conditionality for services, created perceived barriers to adolescents seeking formal sexual and reproductive health services. Several of the young women who experienced unplanned pregnancies described how this environment led them to delay antenatal care. Another study conducted in rural Tanzania also found the condition imposed on pregnant women seeking antenatal care of being required to attend the health facility with one's partner discouraged uptake and attendance (McMahon et al. 2014). Similarly, in a multi-country study conducted in Africa, young people reported difficulty in seeking treatment for STIs associated with being asked to 'bring your partner first'. This resulted in a preference for seeking treatment from traditional healers (Jana et al. 2012).

The expectation and fear that conditions would be imposed on young people before they could receive sexual and reproductive health services was a consistent theme among both young people and adults. The expectations were that young women seeking antenatal care would be required to bring the child's father or a parent to receive services, that seeking contraception would require a parent and that seeking treatment for STIs would require a sexual partner. Young people in particular perceived that this phenomenon was attributable to healthcare providers' reluctance to provide services supporting 'promiscuous' behaviour. A study on providing youth-friendly services in Kenya corroborates this perception to some degree. In that work, healthcare providers reported being torn between their personal cultural values and respecting young people's rights to sexual and reproductive healthcare (Godia et al. 2013).

The policy context surrounding the provision of sexual and reproductive healthcare to young people suggests that structural (macro) factors may also contribute to the conditionality imposed for services. The partner 'condition' may emanate from national guidelines that encourage partner contact tracing for STIs, an important public health measure that could be a barrier to treatment when established as a condition for service. Furthermore, the failure to define 'relevant' and 'appropriate' sexual and reproductive health services for young people, coupled with a lack of clarity around parental engagement in sexual and reproductive health services for adolescents, could create space for interpretation at the service delivery level. A combination of a lack of clarity in policies and guidelines and an environment of stigma at the community level may shape provider attitudes and behaviours and reinforce the conditionality imposed on young people's access to sexual and reproductive health services.

Although the study captured information at the individual and interpersonal (micro) levels, the conditionality imposed at health facilities suggests links to macro-level structural

stigma processes that may shape local-level service implementation. They also indicate potential structural-level intervention opportunities: the development and implementation of clearer policies and guidelines to reduce the influence of micro-level sigma processes on community-level health service delivery to young people.

The findings of this study may be influenced by certain limitations. The study did not comprehensively capture enacted stigma due to its qualitative nature and the limited number of respondents who shared their own experiences with unplanned pregnancy, STIs or contraception. Respondents described their anticipation (or fear) and perception of prevalent stigma more frequently than actual personal experiences. However, both perceived and anticipated stigma are important to explore as they are likely rooted in personal or observed experiences and can influence behaviour. For example, a study in four African countries found that the anticipation of stigma was a barrier to accessing sexual and reproductive health services and information (Biddlecom, Awusabo-Asare, and Bankole 2009). The present study was unable to capture how the stigmatisation process surrounding adolescent sexual and reproductive health and related social factors has changed over time, an important theme recognised in other studies on adolescent sexual and reproductive health in Tanzania (Remes et al. 2009; Wamoyi et al. 2011; Wamoyi, Wight, and Remes 2015). Although the study results are not generalisable beyond the study communities, the process of 'unpacking' the stigmatisation process around unmarried young people's sexual and reproductive health provides insights into how stigma can play out at the community level. Such insights underscore that stigma is one of many complex processes shaping young people's lives. While the term 'stigma' should be used carefully, avoiding the pitfall of using it as a catch-all, these insights also provide potential entry points for stigma-reduction interventions or additional components for existing efforts to improve adolescent access to sexual and reproductive health services.

Changing the pervasive drivers of stigma at both the micro and macro levels is a long-term proposition. The HIV experience demonstrates that in the short-to-intermediate timeframe, actionable steps to reduce stigma do exist (Nyblade et al. 2009; Pulerwitz et al. 2010; HPP 2015; Rao 2016). For example, work on HIV stigma in health facilities revealed that participatory dialogue and training can address HIV stigma drivers, including attitudes towards people living with HIV, a lack of awareness of what stigma is (in terms of everyday language and actions) and policies that hinder stigma-free facility environments (Nyblade et al. 2009; HPP 2015). Recent efforts in Bangladesh demonstrated that such approaches to HIV stigma reduction and existing training tools (Kidd, Clay, and Ciiya 2007) can be successfully adapted to address healthcare provider-perpetuated sexual and reproductive health stigma towards adolescents (Geibel et al. 2017). Integrating stigma-reduction strategies into sexual and reproductive health programmes for young people in sub-Saharan Africa (Wamoyi et al. 2014) could contribute to the ongoing effort to improve young people's health.

Conclusion

Stigma relating to adolescent sexual and reproductive health is a complex social process that exists in a context of power imbalance; it occurs at every socio-ecological level, takes many forms, manifests itself in various ways and both encompasses and is shaped by ever-changing – and often self-reinforcing – social nuances and subtleties that influence adolescents' vulnerability. Recognising these complexities, this exploratory study begins to

unpack the presence and process of stigma surrounding unmarried young people's sexual and reproductive health at the community level. Stigma manifested itself in forms ranging from verbal harassment to physical punishment to social and physical isolation perpetrated by families, community members, peers and healthcare providers. Respondents described stigma, especially anticipated and perceived stigma, as a barrier to young people accessing sexual and reproductive health services. Both young people and adults reported that excessive questioning and scolding at health facilities, as well as requirements to bring sexual partners or parents to receive services, were key access barriers. The pervasiveness and fear of stigma surrounding young people's sexual and reproductive health expressed by respondents and its potential to impede service access suggest that broader and more in-depth explorations are warranted of the process of stigma occurring within communities, particularly in health facilities, and how this process is influenced by larger macro structural stigma processes. It also underscores the need for cautious and nuanced use of the term stigma to ensure that it reflects and unpacks the complexities of the process. Further research on the feasibility of incorporating stigma-reduction strategies into young people's sexual and reproductive health programmes at the community and health facility levels is also needed.

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